

FILED JUN 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 16472
4581

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Adams			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.				c. CITY OR TOWN Quincy		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				e. STREET ADDRESS (If rural, give location) 825 Cherry			
3. NAME OF DECEASED (Type or Print) Emma		a. (First) Katherine		c. (Last) Bocke		4. DATE OF DEATH (Month) (Day) (Year) May 21, 1955	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH May 25, 1873	
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and State or Foreign Country) Quincy, Illinois,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Gottlieb F. Hacker		13b. MOTHER'S MAIDEN NAME Adelaide Bernhardt		14. NAME OF HUSBAND OR WIFE Bernard Bocke			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. Nil.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bernard Bocke, 825 Cherry Quincy, IL			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Gastric Ulcer DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 7 days 4 mos.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. HOW DID INJURY OCCUR? 5400	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from Apr 14, 1955, to May 21, 1955, that I last saw the deceased alive on May 21, 1955, and that death occurred at 11:59P m., from the causes and on the date stated above.			
23a. SIGNATURE C. J. Vermillion, M.D.		23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 5/23/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-22-55		24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.		24d. LOCATION (City, town, or county) (State) Quincy, Ill.	
DATE REC'D BY LOCAL REG MAY 24 1955		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAY 24 1956

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *John J. Harris*

Licensed Embalmer No. *410*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.